Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

Reopenings occur after a decision has been made, generally, to correct an error, in response to suspected fraud, or in response to the receipt of information not available or known to exist at the time the claim was initially processed. A reopening is not an appeal right. It is an administrative procedure under which the entity that made a determination re-examines that decision for a specific reason. The decision to reopen a case is at the discretion of the party who made the determination and is not appealable. Any party subject to a determination may request a reopening. The filing of a request for reopening does not relieve you from your obligation to make payment *as described in or provide services as described in 42 CFR 422.618.*

Typically, reopenings are only requested after the exhaustion of appeal rights. A party may request a reopening even if it still has appeal rights, as long as the guidelines for reopenings are met. For example, if a beneficiary receives an adverse reconsideration determination, but later obtains relevant medical records, he or she may request a reopening rather than a hearing before an ALJ. However, if the beneficiary did not have additional information and just disagreed with the reasoning of the decision, he or she must file for the appeal.

If a party requests a reopening while it still has appeal rights, it also files for the appeal and asks for a continuance until the reopening is decided. If the reopening is denied or the original determination is not revised, the party retains its appeal rights.

2409.1 Guidelines for Reopenings.--Do not reopen a decision unless the request follows these guidelines. Also, follow these guidelines when you are requesting the reopening

- Make the request in writing;
- State the purpose for the reopening. Make clear that you are requesting a reopening. Do not request a reconsideration. *M+C Organizations*/CMPs do not have a right to reconsideration;
- Do not submit a statement of dissatisfaction. It is not grounds to grant a reopening; and
- Make the request within the time frames permitted by HMO Manual Section 2409.2.

2409.2 Time Limits for Reopenings.--Reopenings must be filed:

1. Within 12 months from the date of the notice of the *organization* or reconsideration determination, at the discretion of the party who made the determination;
2. After such 12-month period, but within 4 years after the date of the notice of the *organization* determination, if there is good cause for reopening the determination or decision; or

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

At any time to correct a clerical error or an error on the face of the evidence which affects the determination or decision; or When fraud or similar fault affected the determination or decision.

2409.3 Good Cause for Reopening.--Good cause exists where:

- There is new and material evidence, not readily available at the time of the determination, and consideration of this material may result in a different conclusion,
- There is an error on the face of the evidence which affects the determination or decision; or,
- There is a clerical error in the claim file.

2409.4 Definitions--

Meaning of New and Material Evidence.--New and Material Evidence is evidence not considered when making the previous decision. This evidence must show facts not available previously and possibly result in a different decision. The submittal of any additional evidence is not a basis for reopening. New information also includes an interpretation of existing information (e.g., a different interpretation of a benefit).

Meaning of Clerical Error.--A clerical error includes such human and mechanical errors as mathematics or computational mistakes, inaccurate coding, or computer errors.

Meaning of Error on Face of the Evidence.--An error on the face of evidence exists if the determination or decision is clearly incorrect based on all the evidence present in the appeal file, the SSA files, or HCFA files at the time of determination.

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

RECONSIDERATION BACKGROUND DATA FORM
(Page 1)

I. IDENTIFYING DATA–BENEFICIARY/PARTIES

Beneficiary Name: _____ HIC #: _____ Phone: _____

Address: Deceased? (Y/N) ___

Party Requesting Reconsideration: ___Beneficiary ___Advocate/Representative ___Estate ___Provider as Representative ___Provider-Appellant
Form of Authorization: ___Appointment Rep Form ___POA ___Waiver of Liability ___Guardianship/Conservator ___Attorney ___Executor

Representative Name:
Representative Company: Phone: _____ Fax: _____
Street/PO Box::
City/State/Zip: Email: _____

II. IDENTIFYING DATA–HMO

HMO Name: _____ Address:

Medicare Product Name (if different than HMO Name:_____ Street _____
HCFA Contract #_____ Contract Type : ___Cost ___Risk ___HCPP City _____
Contact Person for this Reconsideration: State _____
Name: _____
Phone: _____ Extension/Mail Box:_____ Fax: _____
Best time to reach (Eastern Daylight Time):_____
Email:_____

III. BACKGROUND INFORMATION

Member's Enrollment Dates:

Current: ___/___/___ (mm/dd/yy) to ___/___/___ (mm/dd/yy)
Prior: ___/___/___ to ___/___/___

Member's Routine Plan Source of Care (on date of denial)
____ Plan Facility (staff model)
____ Contract primary care physician/primary care group
____ Contract multi-specialty group
____ Other:_____

_____ (give NAME of PCP, or primary source of care)

History of Plan Use of Services:
Use of Plan Services, last twelve months: (number visits) _____ PCP/Primary Care center _____ Other

Is there any history which suggests member fails to understand or follow HMO rules? ___no ___yes. If Yes, Explain

Does member face barriers to understanding or complying with HMO rules? (e.g., language barrier, mental incapacity, etc.) ____ no _____ yes (If yes, describe)

Figure 2-20-N-10 Appeals (*This figure has been updated to reflect M+C requirements*) (Continued)

IV. **CASE SUMMARY** *(check one or more categories most applicable to case)*

Service Category (check each that applies)	Denial Type (circle one per service)	In Area
O Physician Services	CD PS RC TC	YES NO
O Mental Health (outpatient)	CD PS RC TC	YES NO
O Acute Hospital Care	CD PS RC TC	YES NO
O Rehabilitation Hospital	CD PS RC TC	YES NO
O Transportation Services	CD PS RC TC	YES NO
O Lab, Imaging, Tests	CD PS RC TC	YES NO
O Emergency Room	CD PS RC TC	YES NO
O Nursing Home Care	CD PS RC TC	YES NO
O Medical Supplies/DME	CD PS RC TC	YES NO
O Dental Care	CD PS RC TC	YES NO
O Chiropractic Care	CD PS RC TC	YES NO
O Pharmacy/formulary	CD PS RC TC	YES NO
O Eye Care	CD PS RC TC	YES NO
O Podiatry	CD PS RC TC	YES NO
O Home Care	CD PS RC TC	YES NO
O Physical, Occupational, or Speech Therapy	CD PS RC TC	YES NO
O Other (specify):	CD PS RC TC	YES NO

Denial Type
CD = claim (retrospective) denial
PS = pre-service authorization denial
RC = reduction in care (including change in level of care)
TC = termination of care or coverage

V. **PROVIDER IDENTIFICATION DATA** *(Complete a line for each provider described in case. Do not limit to denied service if a provider is referenced for other purposes, such as role in referral or claim denial process)*

Provider Name	Type	Specialty	In Area	Relation to Plan	Medical Records
1.					
2.					
3.					
4.					
5.					

Type Codes
1. Hospital
2. SNF
3. Other Facility
4. Freestanding Clinic
5. Home Health Agency
6. Practitioner/professional Corporation
7. Vendor

Relation to Plan Codes:
1. PCP/Member's Primary Care Center
2. Other Plan Provider
3. Non Plan Provider, but under referral from Plan
4. No relationship to Plan

Medical Record Codes
1. Included
2. not applicable
3. not requested
4. requested/refused

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

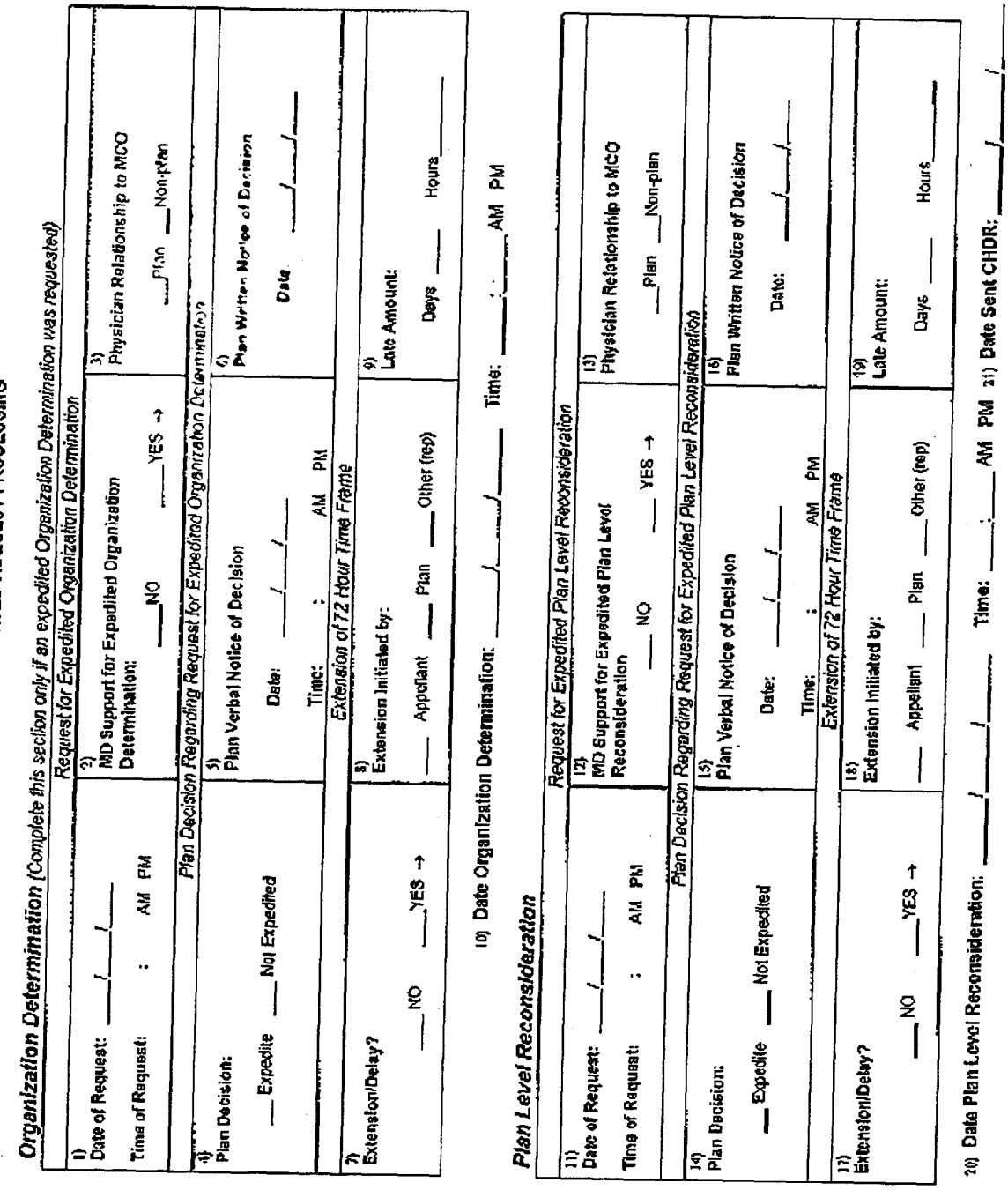
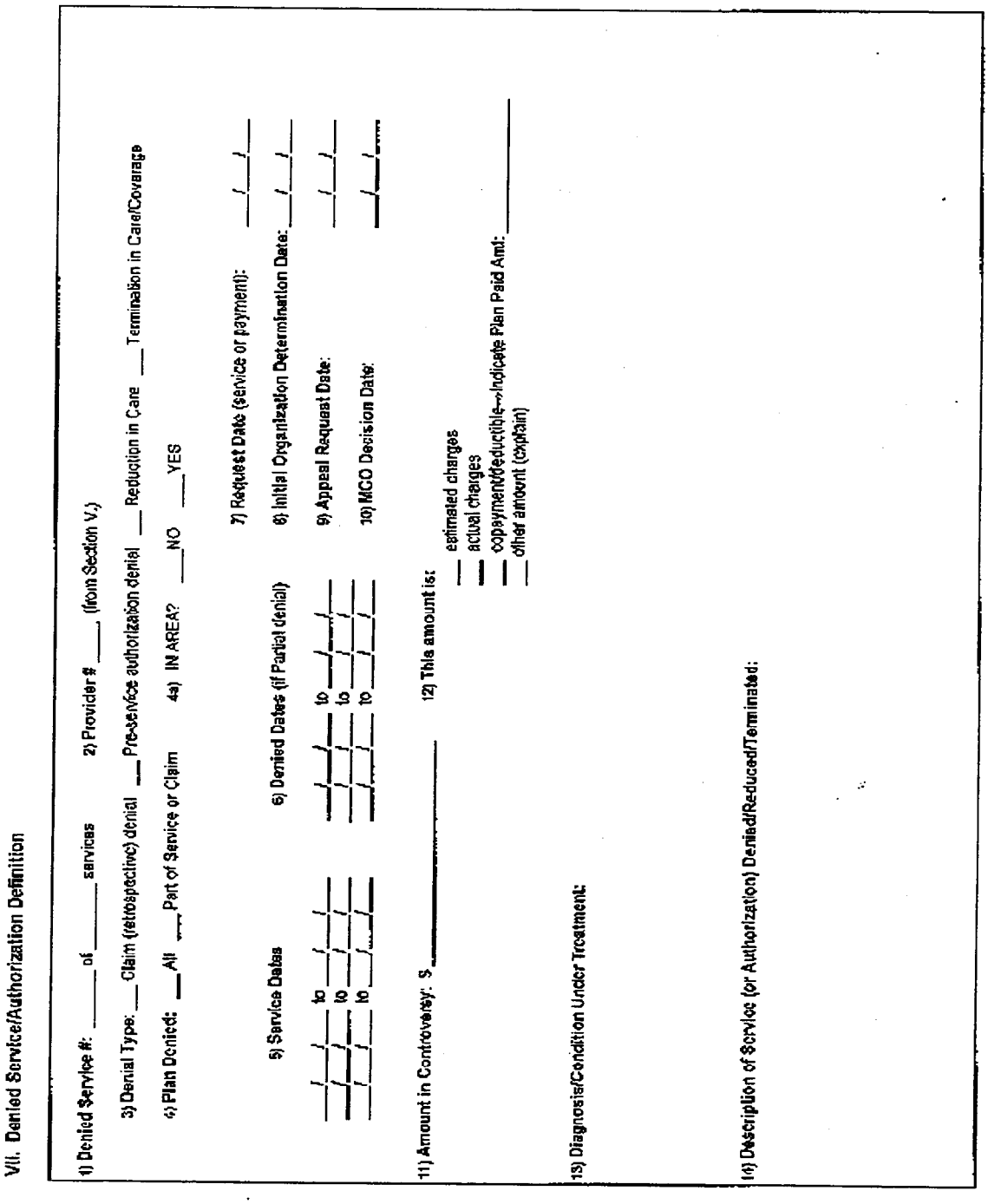


Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)



VII. Denied Service/Authorization Definition

1) Denied Service #: _____ of _____ services 2) Provider # _____ (from Section V.)

3) Denial Type: ___ Claim (retrospective) denial ___ Pre-service authorization denial ___ Reduction in Care ___ Termination in Care/Coverage

4) Plan Denied: ___All ___ Part of Service or Claim 4a) IN AREA? ___NO ___YES

7) Request Date (service or payment): ___/___/___

5) Service Dates 6) Denied Dates (if Partial denial) 8) Initial Organization Determination Date: ___/___/___

___/___/___ to ___/___/___ ___/___/___ to ___/___/___ 9) Appeal Request Date: ___/___/___

___/___/___ to ___/___/___ ___/___/___ to ___/___/___

___/___/___ to ___/___/___ ___/___/___ to ___/___/___ 10) MCO Decision Date: ___/___/___

11) Amount in Controversy: $ _____ 12) This amount is:

___ estimated charges
___ actual charges
___ copayment/deductible—indicate Plan Paid Amt: _____
___ other amount (explain)

13) Diagnosis/Condition Under Treatment:

14) Description of Service (or Authorization) Denied/Reduced/Terminated:

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

CENTER FOR HEALTH DISPUTE RESOLUTION

APPEAL TRANSMITTAL COVER SHEET

For use with any mail transmittal of information on any appeal at CHDR:

Attach one of these forms to each set of documents you send to CHDR for each individual with an appeal. Indicate what type of information you are sending on each case by circling the √ mark. If information is included on an existing appeal, list the CHDR Case Number opposite the appropriate heading. *If you are sending information on multiple cases in one package, include one of these transmittal sheets as the first sheet for each case.*

Document Types	Case Numbers
New case File √	
Requested Information √	
Additional Information, not requested by CHDR √	
Request for Reopening √	
Compliance Notification √	
ALJ Request √	
Withdrawal Request √	

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

CENTER FOR HEALTH DISPUTE RESOLUTION

NOTICE OF CHANGE IN KEY PLAN CONTACT

PLAN CONTACT INFORMATION	
Plan Name	
HCFA Contract Number	
Plan Contact Name	
Plan Contact Title	
Department Title	
Street Address	
Mail Stop	
City	
State	
Zip Code	
Phone Number	
Phone Extension	
Fax Number	
Email Address	

The key Plan contact is the individual to which all general appeal information is to be sent by CHDR. If a Plan chooses to have all appeal case-specific information come to one Plan individual, the key Plan contact will receive that information as well as general information about the appeals program. For this to happen, the key Plan contact must also be listed on the Background Data Form as the Case Specific Plan Contact person.

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

CENTER FOR HEALTH DISPUTE RESOLUTION

RECONSIDERATION REOPENING REQUEST FORM

Beneficiary Name: _____ Appeal Case Number: _____

Beneficiary HIC: _____ Dates of Service: _____ - _____

Health Plan Name: _____

Health Plan Contact: _____

Contact Title: _____

Department: _____

Street Address: _____

Mail Stop: _____

City/State/Zip: _____ _____ _____

Phone Number _____ Ext. _____

Fax Number: _____ Date of Request: _____/_____/_____

Basis of Reopening Request:

☐ Error on the face of the evidence

☐ New and material evidence

☐ Fraud

Explain briefly:

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

APPOINTMENT OF REPRESENTATIVE STATEMENT

Beneficiary Name _____ Medicare Number _____

Provider _____ Dates of Service _____

Health Plan _____

I do hereby swear that I am the above mentioned beneficiary or an authorized representative of the above mentioned beneficiary. I do hereby appoint the following individual _____ to act as my representative in requesting a reconsideration from the Health Plan and/or the Health Care Financing Administration or its designee regarding the services for which the health plan has denied payment or authorization.

Signature _____ Date _____

WAIVER OF PAYMENT STATEMENT

Beneficiary Name _____ Medicare Number _____

Provider _____ Dates of Service _____

Health Plan _____

I hereby waive any right to collect payment from the above mentioned beneficiary for the aforementioned services for which payment has been denied by the Health Plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 417.630.

Signature _____ Date _____

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

CENTER FOR HEALTH DISPUTE RESOLUTION

MEDICARE HMO RECONSIDERATION PROGRAM

NOTICE OF INTENT TO SUBMIT EXPEDITED RECONSIDERATION

(August 1, 1997)

To protect confidentiality, do not include the names of enrollees or providers in this notice.

Enrollee HIC # : _____

Enrollee Initials _____first _____ middle _____ last

Plan Name:_____

Contact Person:_____

Confirm Fax # or E-Mail Address:

_____

Contact Phone # (include extension): _____

Synopsis of Issue:

Recommended Specialty for Review:

medical review will not be required_____

Proposed specialty_____

Schedule Date of Delivery to CHDR:_____
Delivery Vendor: _____

Center for Health Dispute Resolution
Phone: 716-586-1770
Fax: 716 586-2153

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

Medicare Managed Care Reconsideration Program
Instructions for Preparation and Submission of HCFA Level Reconsiderations:

Reconsideration Background Data Form &
Case Narrative Instructions

The Center For Health Dispute Resolution
August 1, 1997

1.0 Scope and Purpose

Under CFR 42 Part 417, Managed Care Organizations (MCOs) that are under contract with HCFA to provide Title XVIII services are required to offer enrollees and non-plan providers access to a 'Reconsideration' of an MCO denial of a claim or service. Under certain circumstances the MCO is required to submit a Reconsideration Case File to HCFA's contract, or The Center for Health Dispute Resolution (CHDR). Consult the CHDR publication, *The Center for Health Dispute Resolution: Medicare Managed Care Reconsideration Process Manual (hereinafter "Manual")*, for general information on this process.

Enclosed in this document are forms ("Reconsideration Background Data Form") and related instructions, for use by Managed Care Organizations (MCOs) in preparation of Reconsideration case files for submission to The Center For Health Dispute Resolution.

These forms and instructions apply to both "expedited" and "routine" Reconsiderations. These materials replace prior versions, in particular the July 25, 1994 version.

2.0 General Information

Procedures and time frames for the submission of case files to CHDR, which vary for expedited vs. routine Reconsiderations, are described in the *Manual*. The forms and instructions herein address only the construction of the actual case file document.

Pursuant to the *Manual*, MCOs will submit a hard copy case file to CHDR by mail or delivery service. The MCO will place the *CHDR Appeal Transmittal Cover Sheet* on top of the case file(s), so that CHDR can clearly differentiate new cases from other incoming materials. (See *Manual, Appendix 1, Forms).*

The actual case file will then include the *Reconsideration Background Data Form*, which is a structured data collection document, with supplementary narrative description and attachments. The requirements for this narrative information are described the attached *Case Narrative Instructions*.

MCOs are permitted to develop and use their own "local" versions of the *Reconsideration Background Data Form*. These local versions must include all the data included in the CHDR version and must be prior approved by CHDR. See the *Manual* for discussion of contact persons at CHDR.

The information that CHDR requires in case files has been developed and refined on the basis of experience processing over 30,000 cases. The information is necessary for a fair evaluation of the Reconsideration, tracking of cases, HCFA compliance or policy considerations. The information is required. It is not recommended or optional, unless expressly noted as such.

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

3.0 Reconsideration Background Data Form Instructions

I. Identifying Data--Beneficiaries/Parties

Beneficiary Name and Address

Provide the last known address even if the beneficiary is deceased. Indicate whether the beneficiary is living or deceased. Include the beneficiary phone number, if know.

The beneficiary information is required even if the Reconsideration is submitted by a non-plan provider or other authorized representative.

Party Requesting Reconsideration

One category must be checked and only one category can apply.

Check "beneficiary" unless one of the following categories applies and is indicated:

Advocate/representative An individual, not including valid representative of an estate or provider, who is authorized to submit a Reconsideration request on behalf of the beneficiary by virtue of execution of an appropriate form of authorization (see below).

Estate An authorized representative of a beneficiary's estate may request a Reconsideration.

Provider as Representative A non plan provider may represent a beneficiary if the case file includes an appointment of representative designating the provider.

Provider-Appellant-A non-plan provider, but not a provider under contract the MCO, may submit a Reconsideration on the provider's behalf if the case file includes an executed "waiver of payment" form.

Form of Authorization

If the beneficiary is not the party, the Plan must check and include an appropriate document authorizing another party or representative.

II. Identifying Data—HMO

The address and contact person entered to this section will be used by CHDR for addressing information to the MCO about this case. The MCO may use the name and address of its Key Plan Contact (see CHDR Manual). Or, the MCO may use a different individual and/or address.

If the Plan contact or address is not entered, CHDR will assume that correspondence is to be sent to the Key Plan Contact.

III. Background Information

Enrollment Dates

Enter the most recent enrollment span. If the member has prior periods of enrollment, note below the "From/To" date fields.

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

Member's Routine Plan Source of Care

By "member's routine source of care" CHDR is referring to the member's "primary care physician" or "medical group" responsible for coordinating the member's care *at the time of the denial in question*. If the member was not assigned to a managing provider, or if the provider was changed during the period in question, so note in available space.

History of Plan Use of Services

The purpose of all questions and fields in this section is to establish whether or not a history of use of Plan services exists and, if so, whether that history indicates compliance or non-compliance with Plan rules. If Plan utilization has occurred, it is sufficient to *estimate* the number of PCP and/or Other encounters within the last 12 months of when the claims were processed.

Note: it is not necessary to include detailed claims for a member's complete utilization history. Records are required only for those claims and services that are denied, and for those services that are necessary to understand the context of, or to evaluate, the denial.

Complete the remainder of this section. Check "no" if this description applies (do not leave blank).

IV. Case Summary

The "Service Categories" are fields that assist CHDR to triage and manage the case and which are used for reporting. The category checked by the MCO will not influence CHDR's evaluation of the case. Check the category that most closely corresponds to the denied service in question. If there are multiple denied services in the case, check each that apply. *Be sure to circle the "denial type" and in-area indicator, for each service category checked.* "Area" refers to the formal service area of the MCO as approved by HCFA.

V. Provider Identification Data

The purpose of this Section is to assist CHDR to correctly identify each provider that is referenced in the Plan's case file. Plans should include the provider(s) of denied, or unauthorized, services, and also any providers who play a role in the case "story" (e.g., a PCP who denied services, an ambulance vendor who took the member to a non-plan ED, etc.). Plans need not identify providers whose only significance is that they are part of the member's general utilization history (i.e., history unrelated to the denied services).

Each provider is recorded in this section *only once* and, thereby, is assigned a number (one to six). If there are more than six providers, use a second sheet and re-number (7 to 12, etc.).

Use your best judgment for selecting codes for "Type" and for entering a specialty. Use of codes 1 to 3 for "Relation to Plan" will cause CHDR to consider the provider a "plan-contracting" provider for purposes of the Reconsideration.

The purpose of the Medical Records fields is to CHDR to rapidly determine if records should be found in the case file and, if not, whether the MCO has attempted to obtain charts. If issues exist regarding sufficiency or availability of medical records, these issues should be discussed in the "case narrative."

VI. Expedited Request Processing

The primary purpose of this section is to support HCFA monitoring of MCO compliance with regulations governing expedited determinations and reconsiderations.

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

Completion of the top half ("Organization Determination") is required if the party had requested an expedited organization determination for any of the denied items included in the case file. *If the MCO did not grant the expedited determination, and/or if the MCO did not complete the determination within the HCFA 72 time standard, attach a brief explanation.*

Completion of the bottom half ("Plan Level Reconsideration") is required if the party had requested an expedited MCO Reconsideration for any of the denied items in the case file. *If the MCO did not grant the expedited Recon, and/or if the MCO did not complete the Recon within the HCFA time frame, attach a brief explanation.*

Note: In cases in which the request for an expedited determination or an expedited Recon are made by phone or in person to the MCO, the MCO must include the "call log" or record of any arguments supplied by the member. Include copies of written requests.

VII. Denied Service/Authorization Definition

One complete copy of this form is required for each separate denied service or authorization contained within the Reconsideration. For example, if an MCO denied an ambulance ride to an Emergency Department, the ED Visit, and a follow-up exam, three completed copies of this section would be required. If only one type of service is in controversy, but that service occurred over a span of time, one form can be used. Examples would include multiple inpatient admissions to the same facility, home health over a period of time, and multiple visits of the same therapy to the same provider.

Sometimes, a Plan will deny two or more related services, but the member will only appeal one of the denied services. Complete a section of this form for each separate denied service, whether or not the member has sought a reconsideration of that service (and indicate the beneficiary request in the appropriate box). For denied services which the member does not appeal, leave the "Appeal Request Date" field blank.

Denied Service #

Enter the number of the denied service which is being described on this copy, and the total number of denied services which will be defined (i.e., the number of completed copies of this form).

Provider #, Denial Type, Plan Denied

Enter the number of the provider from Section 5 that identifies the provider of the denied service (or proposed service). If a provider has not been identified, write "none".

Complete the other self explanatory fields.

Service Date/Denial Dates

The "service dates" (up to three spans permitted) refer to the start and end dates of services which are delivered, irrespective of the MCOs decision to cover or deny these services. The "denial dates" refer to the span of services which the Plan has denied. For a total denial, the service dates and denial dates are the same. The "denial dates" are usually not the date(s) of the MCO's "organization determination" or decision to deny care. The administrative decision date is entered under "Initial Organization Determination."

Enter the start and end dates of service to **Service Dates** (does not apply to pre-service denials). If there are multiple spans of service (e.g., multiple admissions), use more than one line. Within each span of entered Service Dates, enter the span of **Denied Dates**. For example, if a member was in a SNF from

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

1/1/97 until 6/30/97, these would be the Service Dates. If the Plan denied the period 2/1/97 until 3/30/97 these would be the denied dates.

Request Date, Initial Organization Determination Date, Appeal Request Date, MCO Decision Date

These fields are required and, for expedited Reconsiderations, should be consistent with the data entered to Section VI.

Amount in Controversy

The "amount in controversy" is the best estimate of the amount the enrollee would have to pay, or is contesting, based upon the MCO's denial. The amount entered is for the denied service described on this particular form (not the total if two or more services are defined on two or more forms). If this amount is not precisely determined, enter an estimate. Provide an explanation if there is no basis for an estimate (e.g., denial of request for out of network care, where provider has not identified estimated charges).

Check "estimated charges" or "actual charges" if one of these fields explains the basis for the amount in controversy. Included copies of bills or proposed charges for "actual charges."

If the estimated amount in controversy has been computed in some other manner, (e.g., a balance bill above the HMO allowed amount, a copayment, etc.), explain and attach related documentation.

Diagnosis

This space is provided to capture the Plan's understanding of the condition being treated in the episode of care that is denied. A narrative brief description is required, coding is optional.

Service Description

This space is provided for a brief description of the care that was denied. Do not use it to present the rationale for the plan denial.

4.0 Case Narrative Instructions

INTRODUCTION

"Case Narrative" refers to all required components of the case file other than the *Background Data Form*. Case narrative will include text written by the MCO plus material attached to the case file. The case file must be clearly and neatly organized, with legible material and attachments. The required organization and contents are:

1. Appeal Transmittal Cover Sheet
2. Background Data Form
3. Case Narrative Section:
    - Chronology of Events
    - Plan Reason for Denial
        - Summary Statement
        - Justification
    - Member's (Provider's) Arguments for Coverage
    - Plan Rebuttal